



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR  
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BUREAU OF FACILITY STANDARDS  
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February 10, 2009

FEB 11 2009

RECEIVED

FEB 23 2009

FACILITY STANDARDS

Kathy Prophet  
Preferred Community Homes - Fieldstone  
7091 West Emerald Street  
Boise, ID 83704

RE: Preferred Community Homes - Fieldstone, Provider #13G030

Dear Ms. Prophet:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Fieldstone, which was conducted on January 26, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 23, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by February 23, 2009. If a request for informal dispute resolution is received after February 23, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MATT HAUSER  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MH/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/26/2009</b>	
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  The following deficiencies were cited during your annual recertification survey.  The survey was conducted by: Matt Hauser, QMRP, Team Leader Sherri Case, LSW, QMRP  Common abbreviations used in this report are: HRC - Human Rights Committee IPP - Individual Program Plan MAR - Medication Administration Record QMRP - Qualified Mental Retardation Professional			W 000	"Preparation and implementation of this plan of correction does not constitute admission or agreement by Fieldstone with the facts, findings or other statements as alleged by the state agency dated January 26, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Fieldstone - Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE  The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 2 individuals (Individual #1) whose Behavior Management/Support Plans were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals on restrictive interventions. The findings include:  1. Individual #1's IPP, dated 10/13/08, documented a 33 year old female diagnosed with mild to moderate mental retardation, schizoaffective disorder/bipolar type and			W 262	W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE  All client's medications have been reviewed by the AQMRP, QMRP and house nurse to ensure that consents are in place with and including HRC approval. Individual #1's medication Trazadone now has HRC approval.  Person Responsible: QMRP, AQMRP Completion date: 2-19-09  <i>Pen and ink revision: to be monitored quarterly by the QMRP - per the Administrator on 2-25-09.</i> <b>RECEIVED</b> <b>FEB 23 2009</b> <b>FACILITY STANDARDS</b>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 262	Continued From page 1 depressive disorder.  a. Her Medication Administration Record (MAR) documented she received Temazepam (a sedative-hypnotic) 30 mg for sleep upon admission to the facility on 9/10/08 until it was discontinued on 12/22/08. When asked, the QMRP stated on 1/26/09 at 9:50 a.m., HRC approval had not been obtained.  b. Her MAR documented she received Trazodone (an antidepressant) 150 mg on 12/22/08 and decreased to 75 mg on 12/24/08 for sleep. When asked, the QMRP stated on 1/26/09 at 9:50 a.m. HRC approval had not been obtained.  The facility failed to ensure HRC approval was obtained prior to the use of the Temazepam and the Trazodone.	W 262			
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE  The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals for restrictive interventions. The findings include:	W 263	<b>W 263 483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</b>  All client's medications have been reviewed by the AQMRP, QMRP and house nurse to ensure that consents are in place with and including guardian approval. Individual #1's medication Trazadone now has guardian approval.  Person Responsible: QMRP, AQMRP Completion date: 1-28-09  <i>Pen and ink revision: to be monitored quarterly by the QMRP per the Administrator on 2-25-09 by Matt Hauser</i>		

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W 263	<p>Continued From page 2</p> <p>1. Individual #1's IPP, dated 10/13/08, documented a 33 year old female diagnosed with mild to moderate mental retardation, schizoaffective disorder/bipolar type and depressive disorder.</p> <p>a. Her Medication Administration Record (MAR) documented she received Temazepam (a sedative-hypnotic) 30 mg for sleep upon admission to the facility on 9/10/08 until it was discontinued on 12/22/08. When asked, the QMRP stated on 1/26/09 at 9:50 a.m., that written informed consent had not been obtained from the guardian for the Temazepam.</p> <p>b. Her MAR documented she received Trazodone (an antidepressant) 150 mg on 12/22/08 which was decreased to 75 mg on 12/24/08 for sleep. When asked, the QMRP stated on 1/26/09 at 9:50 a.m., that written informed consent had not been obtained from the guardian for the Trazodone.</p> <p>The facility failed to ensure consents for the Temazepam and Trazadone were obtained from Individual #1's guardian prior to the use of the medications.</p>			W 263			
W 312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>This STANDARD is not met as evidenced by:</p>			W 312			

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W 312	<p>Continued From page 3</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 2 individuals (Individuals #1 and #2) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1's IPP, dated 10/13/08, documented a 33 year old female diagnosed with mild to moderate mental retardation, schizoaffective disorder/bipolar type and depressive disorder. She was admitted to the facility on 9/10/08.</p> <p>a. Her Medication Reduction Plan, dated 9/8/08, stated she received Abilify (an antipsychotic), Depakote (an anticonvulsant), Mysoline (an anticonvulsant), Loxapine (an antipsychotic) and Ambien (a sedative-hypnotic) for schizoaffective disorder. The schizoaffective disorder behaviors were defined as disruptive behavior, destruction of property, and she was hurtful to herself and others. The plan stated all medications would be reduced when Individual #1 had 5 or less episodes of disruptive behavior, 1 or less episodes of destruction of property, 1 or less episodes of being hurtful to herself and 1 or less episodes of being hurtful to others. The medications would be reduced after Individual #1 had met criteria for each behavior for 6 consecutive months.</p>			W 312	<p><b>W 312 483.450(E)(2) DRUG USAGE</b></p> <p>Individual #1's and all other individuals living in the Fieldstone facility Medication Reduction Plan has been reviewed and now includes clear and accurate information related to the reduction and eventual elimination of the behaviors for which the medications were employed. Individual #2's and all individuals living in the Fieldstone facility IPP's now includes programs or objectives which address any symptoms of depression or uncooperative behavior.</p> <p>Person Responsible: QMRP, AQMRP Completion date: 1-28-09</p> <p><i>Pen and ink revision: to be monitored by the QMRP and AQMRP per the Administrator on 2-25-09 by Matt Hauser</i></p>		

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W 312	<p>Continued From page 4</p> <p>During interview, on 1/23/09 between 8:40 -10:45 a.m., the Administrator and the QMRP stated Individual #1 did not have objectives for disruptive behavior, destruction of property or being hurtful to others. Individual #1 did have an objective to decrease hurting herself (defined as scratching herself). When asked about the Ambien the QMRP stated the Medication Reduction Plan was inaccurate and Individual #1 did not receive Ambien. The QMRP stated Individual #1 had received Ambien for sleep at the facility she was discharged from, however, Individual #1 currently received Trazodone for sleep and there was no plan to reduce the Trazodone.</p> <p>The facility failed to ensure Individual #1's Medication Reduction Plan included clear and accurate information related to the reduction and eventual elimination of the behaviors for which the medications were employed.</p> <p>2. Individual #2's 11/14/08 IPP stated he was an 18 year old male whose diagnoses included Autism and moderate mental retardation.</p> <p>Individual #2's Medication Administration Record, dated 12/2008, showed he received Citalopram (an antidepressant drug) 40 mg each day and Clonidine (an antihypertensive drug) 0.1 mg, one half tablet (0.05 mg) each day.</p> <p>Individual #2's Written Informed Consent for Citalopram (generic drug for Celexa), dated 11/04/08, documented he received Citalopram for symptoms related to depression. His "Depressive Symptoms Tracking" form showed the following behaviors were being tracked; irritable mood (not further defined), depressed mood (not further</p>	W 312			

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W 312	<p>Continued From page 5</p> <p>defined), diminished interest in activities (not defined), weight loss or gain, change in appetite, change in sleep pattern, psychomotor agitation or retardation (not defined), fatigue or loss of energy, feelings of guilt or worthlessness, decrease in the ability to think, thoughts of death or suicide, crying for no reason, feeling ill (vomiting), and lying on bed (isolating at odd times).</p> <p>However, Individual #2's Medication Reduction Plan, dated 11/2008, stated Citalopram was related to "Uncooperative Behavior" defined as refusal to cooperate. No further information or definitions were included related to Individual #2's uncooperative behavior.</p> <p>Additionally, Individual #2's IPP did not include programs or objectives which addressed his symptoms of depression or uncooperative behavior.</p> <p>When asked, the QMRP stated during an interview on 1/23/09 from 9:50 - 10:15 a.m., Individual #2's Medication Reduction Plan was not accurate, and he did not have a plan to teach him how to cope with or address his depressive symptoms or uncooperative behavior.</p> <p>The facility failed to ensure Individual #2's Medication Reduction Plan was adequately developed.</p>	W 312			

Bureau of Facility Standards

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MM194	16.03.11.075.10(a) Approval of Human Rights Committee  Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 16.03.11.075.10 (a) Approval of Human Rights Committee  Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian  Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM 196 16.03.11.075.10 (c) Consent of Parent or Guardian  Refer to W263	
MM197	16.03.11.075.10(d) Written Plans  Is described in written plans that are kept on file in the facility; and  This Rule is not met as evidenced by: Refer to W312.	MM197	MM 197 16.03.11.075.10 (d) Written Plans  Refer to W312	
MM380	16.03.11.120.03(a) Building and Equipment  The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the	MM380	RECEIVED  FEB 23 2009  FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

B8QF11

TITLE

(X6) DATE

If continuation sheet 1 of 2

Bureau of Facility Standards

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MM380	<p>Continued From page 1</p> <p>facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include:</p> <p>During an environmental review, conducted on 1/22/09 from 11:40 - 12:15 p.m., the following concerns were noted:</p> <ul style="list-style-type: none"> <li>- The cupboard shelf by the kitchen door had bare wood, an uncleanable surface.</li> <li>- There were food crumbs in the silverware drawer.</li> <li>- There were food splatters in the microwave on the top and sides.</li> <li>- The cupboard door under the sink in the kitchen did not close correctly.</li> <li>- The drain in the sink of the bathroom for Individuals #1 and #3 was missing the plug.</li> <li>- There was bare wood, an uncleanable surface, in the bathroom cupboard for Individuals #2 and #4.</li> </ul>	MM380	<p><b>MM380 16.03.11.120.03(a) Building and Equipment</b></p> <p>The uncleanable surface of exposed wood in the cupboard by the kitchen door was addressed and a clean surface now replaces the exposed wood. Completed by 1-26-09</p> <p>Food crumbs in the silverware door have been removed. Completed on 1-26-09</p> <p>Food splatters on the top and sides of the microwave have been removed and cleaned Completed on 1-26-09</p> <p>Maintenance was called and the cupboard door under the sink in the kitchen now closes correctly. Completed 1-26-09</p> <p>Maintenance was called and the missing plug for the bathroom sink for individual #1 and #3's bathroom and that has been ordered. Completed by 3-26-09</p> <p>The uncleanable surface of exposed wood in the bathroom cupboard for individuals #2 and #4 was addressed and a clean surface now replaces the exposed wood. Completed by 1-26-09</p> <p><i>Pen and ink revision: to be monitored monthly by the RSC per the Administrator on 2-25-09 by Matt Houser</i></p>	